PRINTED: 04/11/2011 FORM APPROVED

CENTERS FO	R MEDICARE & MEDIC	CAID SERVICES				OM	IB NO. 0938-0391
STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A DITT	LDING		COMP	LETED
		155286	B. WIN			03/21/2	2011
		1	B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIE	ER .		1	NGSTON CIR		
AVALON	VILLAGE						
				<u>.</u>	IER, IN46767		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTIO		(X5)
PREFIX	`	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROI DEFICIENCY)		COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
F0000	This visit was for	or the investigation of	F00	00			
	Complaint IN00	-					
	Complaint	7000742					
	C 1: A DIO	0006742 G 1 4 4 4 4					
	1 ^	0086742-Substantiated,					
	Federal/State de	eficiencies related to the					
	allegations are of	cited at F223, F225 and					
	F226						
	Survey dates: 3	3/20-21/11					
	Survey dates. 3	7/20-21/11					
	Facilita assault sa						
	Facility number						
	Provider numbe						
	AIM number: 1	100267210					
	Survey team: E	Ellen Ruppel, RN					
		11					
	Census bed type	a·					
	SNF/NF: 46	. .					
	Total: 46						
	Census payor ty	vpe:					
	Medicare: 5						
	Medicaid: 33						
	Other: 8						
	Total: 46						
	10181. 40						
	Sample: 6						
		also reflect state findings in					
	accordance with 41	10 IAC 16.2.					
	I				l		1

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Quality review completed 3-23-11

Cathy Emswiller RN

TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

40JH11

Facility ID:

000184

If continuation sheet

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING		COMPLE	TED
		155286	B. WING			03/21/2011	
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER				NGSTON CIR		
AVALON	VILLAGE		LIGONIER, IN46767				
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	re '	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0223		n observation, interviews	F02	23	Submission of this Plan of Correction does not constitute		04/05/2011
SS=D	and	record review, the facility			and admission or an agreeme		
	failed t	o prevent verbal abuse by			by the provider of the truth of		
		transport driver to 1 of 6			facts alleged or corrections se	t	
		dents whose records were			forth on the statement of deficiencies.The Plan of		
					Correction is prepared and		
	reviewed for	or abuse in a sample of 6.			submitted because of		
		Residents C.			requirements under State and		
					Federal law.Please accept this		
	Findings inclu	de:			Plan of Correction as our cred		
	Tilidiligs lifetu	de.			allegation of compliance.F223 ABUSE PREVENTIONThe fac		
					will ensure this requirement is	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
	During the ori	entation tour, on			met through the following		
	3/20/11 at 2:15	5 p.m., the nurse on			corrective measures:1. Resid	ent	
) indicated Resident			#C was not harmed.2. All		
	C was alert, or				residents have the potential to affected. Resident interviews	be	
	· ·				were conducted as part of the		
	interviewable.	The resident was			facility's investigation and no		
	observed prop	elling her wheel chair			concerns were noted at this		
	throughout the	e facility.			time.3. The Policy and Proced	ure	
	C	,			for Resident Abuse and for		
	The elipical re	cord of Resident C			Reporting Unusual Occurrence was reviewed and no changes		
					are indicated. The staff have		
	was reviewed,	on 3/20/11 at 2:30			been re-educated on the polic	ies	
	p.m., and indic	cated the resident had			and procedures for reporting		
	been sent to th	e local psychiatric			abuse (See Attachment A). Al	'	
		9/11, due to agitation			allegations of abuse will be reported immediately by staff t	. l	
	_				the Administrator. One staff	·	
	•	e had returned on			member will be questioned by	the	
		resident's diagnoses			Administrator or designee dail	у	
	included, but v	were not limited to:			on scheduled work days x4		
	anxiety, multir	ole sclerosis and			weeks, then two times weekly weeks, and then twice monthly		
	•	rder. The most			thereafter to ensure continued		
	capiosive diso	idei. The most			compliance (See Attachment		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		155286	A. BUI B. WIN			03/21/2	011
NAME OF I	PROVIDER OR SUPPLIEF	!	-!		ADDRESS, CITY, STATE, ZIP CODE		
	VILLAGE				NGSTON CIR ER, IN46767		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	LIX, 1140707		(X5)
PREFIX		ICY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	-	COMPLETION
TAG	recent Minimum Data Set (MDS)			TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		DATE
					B).4. The findings of these interviews will be reviewed du	ring	
	assessment, of 3/9/11, indicated she				"ig		
	had no proble	ms with long or short			Assurance Meetings and the p		
	term memory	and was capable of			of action adjusted accordingly. The above corrective measure		
	decision maki	ng.			will be completed on or before 4/05/11.		
	Social service	notes, dated 2/22/11					
		ndicated the resident					
	had told the so	ocial worker that she					
	had "problems	s (with) that girl that					
	_	out places & (and) to					
		" The entry indicated					
	the driver had	"crabbed about					
	everything I b	ought, she said I					
	shouldn't or co	ouldn't buy the things					
	I wanted to bu	y." The entry					
	indicated the r	resident was using an					
	electric cart in	the store and the					
	driver had told	d her not to go down a					
	particular aisle	e, but she did and					
	knocked thing	s down and off the					
	shelves. The	social service note					
	indicated the d	driver had "yelled" at					
	the resident ar	nd told her she would					
	never take her	anywhere again.					
	 During an inte	erview with LPN# 7,					
	on 3/21/11 at 9						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155286			(X2) MULTIPLE CONSTRUCTION (X3) DATE SUIT COMPLET A. BUILDING B. WING 03/21/201				ETED
NAME OF I	PROVIDER OR SUPPLIEI	₹	-	1	ADDRESS, CITY, STATE, ZIP CODE	•	
AVALON	VILLAGE		200 KINGSTON CIR LIGONIER, IN46767				
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	(X5) COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	indicated she	•					
	Resident C, on Sunday 2/20/11 and						
	was told by th	e resident the					
	transport drive	er had yelled at her					
	and told her sl	he would never take					
	her to (name of	of department store)					
	again. LPN#	7 indicated she had					
	reported the in	ncident to the					
	weekend supe	ervisor (LPN# 10), as					
	the facility po	licy indicated. She					
	indicated she	knew the weekend					
	supervisor wa	s to call the					
	Administrator	when an allegation					
	of abuse occur	rred. She also					
	indicated she	was unsure if the					
	weekend supe	rvisor had notified					
	1 *	ator, so she had					
		dministrator of the					
	incident.						
	The investigat	tion of the incident					
	1	on 3/21/11 at 10:00					
		dicated the transport					
		d been involved and					
		supervisor who had					
	failed to repor	_					
	_	o the Administrator					
	had been susp						
	i iau oceii susp	chiqua anu					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155286			A. BUI	LDING	NSTRUCTION	(X3) DATE (COMPL 03/21/2	ETED
	PROVIDER OR SUPPLIER		B. WIN	STREET A	DDRESS, CITY, STATE, ZIP CODE GSTON CIR ER, IN46767		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		TE	(X5) COMPLETION DATE	
	subsequently t 2/22/11.	erminated on					
	prevention pol DoN, on 3/20/ indicated the A be immediatel suspected abus An interview 3/21/11 at 10:3 no concerns of or abusive with she would tell any problems member or oth	Resident C, on 30 a.m., indicated she f anyone being rude h her. She indicated the nurse if she had with any staff					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155286			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED 03/21/2011	
		.00200	B. WIN				
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
AVALON	VILLAGE		200 KINGSTON CIR LIGONIER, IN46767				
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	E	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0225	Based on obse	rvation, interviews	F02	25	F225 ABUSE/NEGLECT REPORTED TO		04/05/2011
SS=D	and record rev	iew, the facility			ADMINISTRATIONThe facility	will	
	failed to imple	ment the policy of			ensure this requirement is met	:	
	reporting imm	ediately to the			through the following corrective		
		the allegation of			measures:1. Resident #C wa not harmed.2. All residents ha		
	verbal abuse b				the potential to be affected.	-	
		· · · · · · · · · · · · · · · · · · ·			Residents were interviewed as		
	-	er to 1 of 6 residents			part of the facility's investigation and no concerns were noted a		
		were reviewed for			this time. 3. The Policy and		
	abuse in a sam	ple of 6. Residents			Procedure for Resident Abuse		
	C.				and for Reporting Unusual	ما	
					Occurrences was reviewed an no changes are indicated. The	-	
	Findings inclu	de·			staff have been re-educated or		
					the policies and procedures fo		
	During the ori	ontation tour on			reporting abuse (See Attachme A). All allegations of abuse wi		
	•	entation tour, on			be reported immediately by sta		
		5 p.m., the nurse on			to the Administrator. One state		
	• `) indicated Resident			member will be questioned by		
	C was alert, or	riented and			Administrator or designee daily on scheduled work days x4	y	
	interviewable.	The resident was			weeks, then two times weekly	x 4	
	observed prop	elling her wheel chair			weeks, and then twice monthly	/	
	throughout the	•			thereafter to ensure continued		
	an oughout the				compliance (See Attachment B).4. The findings of these		
	The clinical	cord of Resident C			interviews will be reviewed dur	ing	
					the facility's quarterly Quality		
		on 3/20/11 at 2:30			Assurance Meetings and the p of action adjusted accordingly.		
	* 1	cated the resident had			The above corrective measure		
	been sent to th	e local psychiatric			will be completed on or before		
	hospital, on 3/	9/11, due to agitation			4/05/11.		
	and anger. Sh	e had returned on					
		resident's diagnoses					
	5,15,11. THE	Coracii o diagnosco					

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION			COMPL	
		155286	A. BUI B. WIN	ILDING		03/21/2	
			D. WII		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER		200 KINGSTON CIR				
AVALON	VILLAGE			LIGONI	ER, IN46767		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION DATE
	included, but v	were not limited to:					
	ŕ	ple sclerosis and					
		order. The most					
	recent Minimu	ım Data Set (MDS)					
	assessment, of	3/9/11, indicated she					
	had no probler	ns with long or short					
	term memory	and was capable of					
	decision makin	ng.					
	Social service	notes, dated 2/22/11					
	at 8:35 a.m., ii	ndicated the resident					
	had told the so	ocial worker that she					
	had "problems	s (with) that girl that					
		ut places & (and) to					
		" The entry indicated					
		"crabbed about					
		ought, she said I					
		ouldn't buy the things					
		y." The entry					
		resident was using an					
		the store and the					
		l her not to go down a					
	_	e, but she did and					
	_	s down and off the					
		social service note					
		driver had "yelled" at					
		nd told her she would					
	never take ner	anywhere again.					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		155286	A. BUII B. WIN			03/21/2	011
	PROVIDER OR SUPPLIER			STREET A	DDRESS, CITY, STATE, ZIP CODE GSTON CIR ER, IN46767	1	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR During an inte	CATATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) ETVIEW WITH LPN# 7,		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
	was told by the transport driver and told her shader to (name of again. LPN# reported the interported the interported the interported the interported the interported the facility politicated she had a larger with a supervisor was a definitely politicated she had weekend supervisor was reviewed, and it interported the Administration of abuse occur indicated she had weekend supervisor. The investigate was reviewed, a.m., and it interported the Administration of the investigate was reviewed, a.m., and it interported the had a driver who had a dri	nad spoken to a Sunday 2/20/11 and be resident the er had yelled at her he would never take of department store) 7 indicated she had heident to the rvisor (LPN# 10), as licy indicated. She knew the weekend is to call the when an allegation					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155286			(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION	COMPI	(X3) DATE SURVEY COMPLETED 03/21/2011		
	PROVIDER OR SUPPLIEF	<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE 200 KINGSTON CIR LIGONIER, IN46767					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	D BE	(X5) COMPLETION DATE		
	had been susp subsequently to 2/22/11. Review of the prevention polynomy, on 3/20/2 indicated the Abe immediated suspected abuse. An interview 3/21/11 at 10:2 no concerns of or abusive with she would tell any problems member or other subsequences.	o the Administrator ended and terminated on 1/2006 facility abuse licy provided by the //11 at 2:30 p.m., Administrator would y notified of se. Resident C, on 30 a.m., indicated she f anyone being rude h her. She indicated the nurse if she had with any staff						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 155286 03/21/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 200 KINGSTON CIR **AVALON VILLAGE** LIGONIER, IN46767 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE F226 DEVELOP/IMPLEMENT F0226 F0226 04/05/2011 Based on observation, interviews POLICIES/PROCEDURES SS=D and record review, the facility **PREVENT** MISTREATMENT/NEGLECT/AB failed to implement the policy of USEThe facility will ensure this reporting immediately to the requirement is met through the Administrator the allegation of following corrective measures:1. Resident #C was not harmed.2. verbal abuse by the transport driver All residents have the potential to to 1 of 6 residents whose records be affected. Residents were interviewed as part of the facility's were reviewed for abuse in a investigation and no concerns sample of 6. Residents C. were noted at this time. 3. The Policy and Procedure for Resident Abuse and for Reporting Findings include: Unusual Occurrences was reviewed and no changes are indicated. The staff have been During the orientation tour, on re-educated on the policies and 3/20/11 at 2:15 p.m., the nurse on procedures for reporting abuse (See Attachment A). All duty (LPN # 4) indicated Resident allegations of abuse will be C was alert, oriented and reported immediately by staff to the Administrator. One staff interviewable. The resident was member will be questioned by the observed propelling her wheel chair Administrator or his designee daily on scheduled work days x4 throughout the facility. weeks, then two times weekly x 4 weeks, and then twice monthly The clinical record of Resident C thereafter to ensure continued compliance (See Attachment was reviewed, on 3/20/11 at 2:30 B).4. The findings of these p.m., and indicated the resident had interviews will be reviewed during the facility's quarterly Quality been sent to the local psychiatric Assurance Meetings and the plan hospital, on 3/9/11, due to agitation of action adjusted accordingly.5. The above corrective measures and anger. She had returned on will be completed on or before 3/15/11. The resident's diagnoses 4/05/11. included, but were not limited to:

000184

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155286			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED 03/21/2011	
		133200	B. WIN	B. WING STREET ADDRESS, CITY, STATE, ZIP CODE			011
NAME OF I	PROVIDER OR SUPPLIER			1	IGSTON CIR		
AVALON	VILLAGE			LIGONI	ER, IN46767		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
	anxiety, multiple explosive disorecent Minimulassessment, of had no problem term memory decision making. Social service at 8:35 a.m., in had told the social material	ole sclerosis and rder. The most im Data Set (MDS) 3/9/11, indicated she ms with long or short and was capable of					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155286		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED 03/21/2011		
		100200	B. WIN			03/21/2	UII
	PROVIDER OR SUPPLIER VILLAGE			200 KIN	DDRESS, CITY, STATE, ZIP CODE IGSTON CIR ER, IN46767		
(X4) ID		TATEMENT OF DEFICIENCIES		ID			(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	~~~~	DATE
	During an inte	erview with LPN# 7,					
	on 3/21/11 at 9	9:40 a.m., she					
	indicated she l	nad spoken to					
	Resident C, or	Sunday 2/20/11 and					
	was told by the	e resident the					
	transport drive	er had yelled at her					
	and told her sh	ne would never take					
	her to (name o	of department store)					
	again. LPN# '	7 indicated she had					
	reported the in	cident to the					
	weekend super	rvisor (LPN# 10), as					
	the facility pol	licy indicated. She					
	indicated she l	knew the weekend					
	supervisor was	s to call the					
	Administrator	when an allegation					
	of abuse occur	red. She also					
	indicated she v	was unsure if the					
	weekend super	rvisor had notified					
	_	ator, so she had					
		dministrator of the					
	incident.						
	The investigat	ion of the incident					
		on 3/21/11 at 10:00					
	· ·	dicated the transport					
	· ·	d been involved and					
		upervisor who had					
	failed to repor	•					

000184

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155286		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 03/21/2011		
	PROVIDER OR SUPPLIER		B. WIN	STREET A	LDDRESS, CITY, STATE, ZIP CODE IGSTON CIR ER, IN46767	1	
	SUMMARY S (EACH DEFICIENT REGULATORY OR immediately to had been suspensive subsequently to 2/22/11. Review of the prevention polypoly indicated the A be immediately suspected abused and interview 3/21/11 at 10:20 no concerns of or abusive with she would tell any problems a member or other support of the support of the suspected abused as a support of the su	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) To the Administrator ended and erminated on 1/2006 facility abuse icy provided by the 11 at 2:30 p.m., Administrator would y notified of se. Resident C, on 30 a.m., indicated she f anyone being rude the her. She indicated the nurse if she had with any staff	b. Why	STREET A	IGSTON CIR	NTE .	(X5) COMPLETION DATE

AND PLAN OF CORRECTION IDENT		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155286	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		COMI	(X3) DATE SURVEY COMPLETED 03/21/2011	
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 200 KINGSTON CIR LIGONIER, IN46767				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION		(X5) COMPLETION DATE	